

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No.

7392

FILED MAR 16 1942  
Registration District No. 288

Primary Registration District No. 4362

Registrar's No.

9

## 1. PLACE OF DEATH:

(a) County Newton  
(b) City or town Fairview, Tenn  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: /  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community Most all of life years, months or days)

3. (a) PRINT FULL NAME Clarence E. White3. (b) If veteran,  
name war \_\_\_\_\_

3. (c) Social Security

60-072465

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Sarah E. White  
6. (c) Age of husband or wife if alive 57 years  
7. Birth date of deceased April 24 1886  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>55</u>	<u>8</u>	<u>28</u>	hr. min.

9. Birthplace Wanda Missouri  
(City, town, or county) (State or foreign country)10. Usual occupation Laborer & Farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name James White  
13. Birthplace Tenn. (City, town, or county) (State or foreign country)  
14. Maiden name Laura Ellis  
15. Birthplace Tenn. (City, town, or county) (State or foreign country)

16. (a) Informant Beth Clanton(b) Address Granby, Missouri17. (a) Burial (Burial, cremation, or removal) (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)(c) Place: burial or cremation Dice18. (a) Signature of funeral director Horine & Culver(b) Address Cassville, Missouri19. (a) Feb 20 42 (Date received local registrar) (b) Dana Gerster (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Newton  
(c) City or town Fairview  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 28  
year 1942 hour 7 ; 50 minute P. M.21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_,  
and that death occurred on the date and hour stated above.Immediate cause of death Natural Cause Duration  
Died suddenly  
Probably Heart DiseaseDue to \_\_\_\_\_  
Due to \_\_\_\_\_Other conditions  
(Include pregnancy within 3 months of death)Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

## PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? \_\_\_\_\_ (Specify type of place)  
(c) Means of injury \_\_\_\_\_23. Signature J. H. Reynolds (M.D. or other)  
Address Newton, Mo Date signed 2-22-42

RECEIVED.

District Health Officer No: 6,

District File Number 342-390

Date Filed MAR 13 1942

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No. ....

working under my personal supervision.

Signed.....

Licensed Embalmer No. 3384

P. O. Address.....

**Note:** The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

This man died suddenly.  
No physician had attended  
him. No diagnosis had  
been made. There was no  
autopsy performed. An  
investigation made by  
Coroner after death.  
J. R. Reynolds Coroner

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No.

7392

Registration District No.

608

Primary Registration District No.

4362

Registrar's No.

1. PLACE OF DEATH:

- (a) County Newton  
(b) City or town Harvey  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. (Specify whether  
In this community years, months or days)

3. (a) PRINT FULL NAME

Clarence E. White

3. (b) If veteran,  
name war.

3. (c) Social Security  
No.

4. Sex m

5. Color or  
race w

6. (a) Single, widowed, married,  
divorced w

6. (b) Name of husband or wife.

6. (c) Age of husband or wife if  
alive.

7. Birth date of deceased

Apr 24 18  
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

(If less than one day

55

8

28

min.

9. Birthplace

(City, town, or county)

(State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

(City, town, or county)

(State or foreign country)

14. Maiden name

15. Birthplace

(City, town, or county)

(State or foreign country)

16. (a) Informant

(b) Address

17. (a)

(Burial, cremation, or removal)

(b) Date thereof

(Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a)

(Date received local registrar)

(b)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State (b) County  
(c) City or town (If outside city or town limits, write "RURAL")  
(d) Street No. (If rural, give location)  
(e) Citizen of foreign country? (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day year hour minute M.

21. I hereby certify that I attended the deceased from  
that I last saw him alive on  
and that death occurred on the date and hour stated above.  
Immediate cause of death

Heart Disease

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

PHYSICIAN

Underline  
the cause to  
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22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify)  
(b) Date of occurrence  
(c) Where did injury occur? (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place)  
While at work? (e) Means of injury

23. Signature (M. D. or other)  
Address Date signed

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY